§ 434.65 Services included in the State plan but not covered by the contract.

If the contract does not cover all services available under the State plan, the agency must arrange for services not included to be available and accessible. This may be done by having the contractor refer enrolled recipients to other providers or by some other means.

§ 434.67 Sanctions against HMOs with risk comprehensive contracts.

(a) *Basis for imposition of sanctions.* The agency may recommend that the intermediate sanction specified in paragraph (e) of this section be imposed if the agency determines that an HMO with a risk comprehensive contract does one or more of the following:

(1) Fails substantially to provide the medically necessary items and services required under law or under the contract to be provided to an enrolled recipient and the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual.

(2) Imposes on Medicaid enrollees premium amounts in excess of premiums permitted.

(3) Engages in any practice that discriminates among individuals on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, or any practice that could reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by section 1903(m) of the Act) by eligible individuals whose medical conditions or histories indicate a need for substantial future medical services.

(4) Misrepresents or falsifies information that it furnishes, under section 1903(m) of the Act to CMS, the State agency, an individual, or any other entity.

(5) Fails to comply with the requirements of §§ 417.479(d) through (g) of this chapter relating to physician incentive plans, or fails to submit to the State Medicaid agency its physician incentive plans as required or requested in § 434.70.

(b) *Effect of an agency determination.* (1) When the agency determines that an HMO with a risk comprehensive contract has committed one of the violations identified in paragraph (a) of this section, the agency must forward this determination to CMS. This determination becomes CMS's determination for purposes of section 1903(m)(5)(A) of the Act, unless CMS reverses or modifies the determination within 15 days.

(2) When the agency decides to recommend imposition of the sanction specified in paragraph (e) of this section, this recommendation becomes CMS's decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within 15 days.

(c) *Notice of sanction.* If a determination to impose a sanction becomes CMS's determination under paragraph (b)(2) of this section, the agency must send a written notice to the HMO stating the nature and basis of the proposed sanction. A copy of the notice is forwarded to the OIG at the same time it is sent to the HMO. The agency allows the HMO 15 days from the date it receives the notice to provide evidence that it has not committed an act or failed to comply with a requirement described in paragraph (a) of this section, as applicable. The agency may allow a 15-day addition to the original 15 days upon receipt of a written request from the organization. To be approved, the request must provide a credible explanation of why additional time is necessary and be received by CMS before the end of the 15-day period following the date the organization received the sanction notice. An extension is not granted if CMS determines that the organization's conduct poses a threat to an enrollee's health and safety.

(d) *Informal reconsideration.* (1) If the HMO submits a timely response to the agency's notice of sanction, the agency conducts an informal reconsideration that includes—

(i) Review of the evidence by an agency official who did not participate in the initial recommendation to impose the sanction; and

(ii) A concise written decision setting forth the factual and legal basis for the decision.